SENATE BILL 472
By Roberts

HOUSE BILL 574

By Howell

AN ACT to amend Tennessee Code Annotated, Title 56; Title 63 and Title 68, relative to health care.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new part:

56-7-3501. This part shall be known and may be cited as the "Tennessee Right to Shop Act."

56-7-3502. As used in this part:

(1) "Allowed amount" means the contractually agreed upon amount paid by a carrier to a healthcare entity participating in the carrier's network;

(2) "Healthcare entity" means:

(A) Any healthcare facility licensed under title 68; and

(B) Any healthcare provider licensed under title 63 or 68;

(3) "Health insurance coverage" has the same meaning as defined in § 56-7-109;

(4) "Insurance carrier" or "carrier" means a health insurance entity as defined in § 56-7-109;

(5) "Program" means the shared savings incentive program established by a carrier pursuant to this section; and

(6) "Shoppable healthcare service" means a healthcare service for which a carrier offers a shared savings incentive payment under a program established by the carrier pursuant to this part.

56-7-3503.

(a) Prior to a non-emergency admission, procedure, or service and upon request by a patient or prospective patient, a healthcare entity within the patient's or prospective patient's insurer network shall, within two (2) working days, disclose the allowed amount of the non-emergency admission, procedure, or service, including the amount for any required facility fees.

(b) Prior to a non-emergency admission, procedure, or service and upon request by a patient or prospective patient, a healthcare entity outside the patient's or prospective patient's insurer network shall, within two (2) working days, disclose the amount that will be charged for the non-emergency admission, procedure, or service, including the amount for any required facility fees.

(c) If a healthcare entity is unable to quote a specific amount under subsection (a) or (b) in advance due to the healthcare entity's inability to predict the specific treatment or diagnostic code, the healthcare entity shall disclose what is known for the estimated amount for a proposed non-emergency admission, procedure, or service, including the amount for any required facility fees. A healthcare entity must disclose the incomplete nature of the estimate and inform the patient or prospective patient of the right to obtain an updated estimate once additional information is determined.

(d) If a patient or prospective patient has health insurance coverage, a healthcare entity that participates in a carrier's network shall, upon request of a patient or prospective patient, provide, based on the information available to the healthcare entity at the time of the request, sufficient information regarding the proposed non-emergency admission, procedure, or service for the patient or prospective patient to receive a cost estimate from their carrier to identify out-of-pocket costs, which could be through an applicable toll-free telephone number, website, or access to a third-party service. A healthcare entity may assist a patient or prospective patient in using a carrier's toll-free number, website, or third-party service.

53-7-3504. A carrier shall establish an interactive mechanism on its publicly accessible website that enables an enrollee to request and obtain from the carrier, or a designated third-party, information on the payments made by the carrier to network providers for healthcare services. The interactive mechanism shall allow an enrollee seeking information about the cost of a particular healthcare service to compare costs among network providers as established in § 53-7-3503.

53-7-3505.

(a) Within two (2) working days of an enrollee's request, a carrier shall provide a good faith estimate of the allowed amount and the amount the enrollee will be responsible to pay out-of-pocket for a proposed non-emergency procedure or service that is a medically necessary covered benefit from a carrier's network provider, including any copayment, deductible, coinsurance, or other out-of-pocket amount for any covered benefit, based on the information available to the insurance carrier at the time the request is made.

(b) Nothing in this section shall prohibit an insurance carrier from imposing cost-sharing requirements disclosed in the enrollee's health insurance coverage contract for unforeseen healthcare services that arise out of the non-emergency procedure or service or for a procedure or service provided to an enrollee that was not included in the original estimate.

(c) A carrier shall notify an enrollee that these are estimated costs, and that the actual amount the enrollee will be responsible to pay may vary due to unforeseen services that arise out of the proposed non-emergency procedure or service.

56-7-3506.

(a) A carrier shall develop and implement a shoppable healthcare program as an optional benefit for enrollees. The shoppable healthcare program shall provide

incentives to enrollees who elect to receive covered shoppable healthcare services from providers that charge less than the average price paid by that carrier for that shoppable healthcare service.

(b) The shoppable healthcare program shall identify shoppable healthcare services. Healthcare services in the following categories shall be identified as shoppable healthcare services:

(1) Physical and occupational therapy services;

(2) Obstetrical and gynecological services;

(3) Radiology and imaging services;

(4) Laboratory services;

(5) Infusion therapy;

(6) Inpatient and outpatient surgical procedures;

(7) Outpatient non-surgical diagnostic tests or procedures; and

(8) Any other service identified by a carrier as a shoppable healthcare service.

(c) A carrier shall make the incentive program available as a component of all health plans offered by the carrier in this state. Annually at enrollment or renewal, a carrier shall provide notice about the availability of the program to any enrollee who is enrolled in a health plan eligible for the program.

(d) The carrier shall provide the incentive as a cash payment to the enrollee. Incentives may be calculated as a percentage of the difference in price, as a flat dollar amount, or by some other reasonable methodology approved by the commissioner of commerce and insurance. A carrier is not required to provide a payment or credit to an enrollee when the carrier's saved cost is fifty dollars ($50) or less.

(e) The incentive program shall return at least fifty percent (50%) of the carrier's aggregate saved costs for each service or category of shoppable healthcare service resulting from shopping by enrollees to enrollees as incentives.

(f) A carrier will base the average price on the average paid to an in-network provider for the procedure or service under the enrollee's health insurance coverage plan within a reasonable timeframe, not to exceed one (1) year. A carrier may determine an alternate methodology for calculating the average price if approved by the commissioner of commerce and insurance.

56-7-3507. Prior to offering the program to any enrollee, a carrier shall file a description of the program established by the carrier pursuant to this section with the commissioner of commerce and insurance in the manner determined by the commissioner. The commissioner may review the filing made by the carrier to determine if the carrier's program complies with the requirements of this part. Filings and any supporting documentation made pursuant to this section are confidential until the filing has been reviewed or the waiver request has been granted or denied by the commissioner.

56-7-3508. If an enrollee elects to receive a shoppable healthcare service from an out-of-network provider that results in a shared savings incentive payment, a carrier shall apply the amount paid for the shoppable healthcare service toward the enrollee's member cost sharing as specified in the enrollee's health plan as if the healthcare services were provided by an in-network provider.

56-7-3509. A shared savings incentive payment made by a carrier in accordance with this section is not an administrative expense of the carrier for rate development or rate filing purposes.

56-7-3510.

(a) Annually a carrier shall file with the commissioner of commerce and insurance for the most recent calendar year:

(1) The total number of shared savings incentive payments made pursuant to this part;

(2) The use of shoppable healthcare services by category of service for which shared savings incentives are made;

(3) The total payments made to enrollees;

(4) The average amount of incentive payments made by service for such transactions;

(5) The total savings achieved below the average prices by service for such transactions; and

(6) The total number and percentage of a carrier's enrollees that participated in such transactions.

(b) Beginning April 1, 2018, and by April 1 of each year thereafter, the commissioner of commerce and insurance shall submit an aggregate report for all carriers filing the information required by this section to the chair of the commerce and insurance committee of the senate and the chair of the insurance and banking committee of the house of representatives.

56-7-3511. The commissioner of commerce and insurance is authorized to promulgate rules to effectuate the purposes of this act. The rules shall be promulgated in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. This act shall take effect July 1, 2017, the public welfare requiring it. This act shall apply to all policies or contracts entered into, renewed, amended, or delivered on or after July 1, 2017.